

Dental Plans Comparison Chart					
	SAFEGUARD	DELTACARE	DELTA DENTAL PLAN		
			DELTA PREFERRED OPTION DENTIST IN-NETWORK	DELTA PARTICIPATING DENTIST IN-NETWORK	OUT-OF-NETWORK
Type of Plan	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers two provider networks and out-of-network benefits		
Annual Deductible	None	None	None	\$50/person; \$150/family	\$50/person; \$150/family
Annual Maximum Benefit	None	None	\$1,750/person (all care must be in DPO network)	\$1,500/person	\$1,500/person
PREVENTIVE CARE					
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two/calendar year)	80% (no deductible on first two cleanings/calendar year)	80% of R&C (no deductible on first two cleaning/calendar year)
Exam	100%	100%	100% (two/calendar year)	80% (two/calendar year)	80% of R&C (two/calendar year)
Full Mouth X-Rays	100% (one every 24 months)	100% (one every 24 months)	100% (one every five years)	80% (one every five years)	80% of R&C (one every five years)
BASIC SERVICES					
Emergency Treatment	\$5 copay	\$5 copay	100%	80%	80% of R&C
Extractions	100% (except \$50 copay for bony impactions)	100% (except \$50 copay for bony impactions)	85%	80%	80% of R&C
Fillings	100%	100%	85%	80%	80% of R&C
General Anesthesia	30% copay for medically necessary extractions only	30% copay for medically necessary extractions only	85% for oral surgery only	80% for oral surgery only	80% of R&C for oral surgery only
Gingivectomy	\$55 copay/quadrant	\$55 copay/quadrant	85%	80%	80% of R&C
Root Canals	\$45 copay/canal	\$45 copay/canal	85%	80%	80% of R&C
MAJOR SERVICES					
Bridges	\$60 copay/unit	\$60 copay/unit	50% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Crowns	\$60 copay/crown	\$60 copay/crown	85% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Dentures	\$70 copay/denture	\$70 copay/denture	50% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Orthodontia	\$1,000 copay + \$150 start-up fees	\$1,150 copay + \$350 start-up fees	50% (\$1,200 lifetime maximum)	50% (\$1,200 lifetime maximum)	50% (\$1,200 lifetime maximum)
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered

Contact Information		
Contact	Phone Number	Web Site
COUNTY DEPARTMENT OF HUMAN RESOURCES		
Benefits Hotline	213-388-9982	N/A
Web site	N/A	http://dhr.lacounty.info/
BENEFITS SYSTEM		
Web enrollment	N/A	mylacountybenefits.com
Telephone enrollment	888-822-0487	N/A
Fax	310-788-8775	N/A
MEDICAL		
Kaiser Permanente	800-464-4000	my.kp.org/ca/countyofla
Anthem Blue Cross CaliforniaCare HMO	800-227-3771	www.anthem.com/ca/countyoflosangeles
Anthem Blue Cross PLUS POS	800-288-6921	www.anthem.com/ca/countyoflosangeles
Anthem Blue Cross Prudent Buyer PPO	800-288-2539	www.anthem.com/ca/countyoflosangeles
Anthem Blue Cross Catastrophic Plan	800-288-2539	www.anthem.com/ca/countyoflosangeles
DENTAL		
SafeGuard	800-880-1800	www.safeguard.net
DeltaCare	800-422-4234	deltadentalins.com
Delta Dental	888-335-8227	deltadentalins.com
FLEXIBLE SPENDING ACCOUNTS		
Administrator (Cerdian)	866-300-2303	mylacountybenefits.com
Fax	888-367-3305	N/A
LIFE		
MetLife	800-846-0124	mylacountybenefits.com • Click on the MetLife link
AD&D		
CIGNA Life	800-842-6635	cigna.com

 Indicates Plan Changes

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flex



2010 Annual Benefits Medical and Dental Plans Comparison Chart

What's Changing in 2010*

- **Your *Flex* plan choices are not changing for 2010.** However, due to continued increases in the cost of health care, monthly medical premiums, and most dental premiums, will increase next year. See your *Personalized Enrollment Worksheet* for premium rates for 2010.
- **Delta Dental** participating dentist in-network and out-of-network annual maximum benefit will increase to \$1,500 from \$1,200.
- **Mental health and substance abuse** benefits have been enhanced for all plans to comply with the Mental Health Parity Act.
- **Accidental death and dismemberment insurance** rates will decrease.

** Benefit plans and premium rate changes are subject to final approval by the Board of Supervisors.*

2010 MegaFlex Annual Benefits Medical and Dental Plans Comparison Chart

Medical Plans Comparison Chart								
	KAISER PERMANENTE HMO	ANTHEM BLUE CROSS CALIFORNIACARE HMO	ANTHEM BLUE CROSS PLUS POS			ANTHEM BLUE CROSS PRUDENT BUYER PPO		ANTHEM BLUE CROSS CATASTROPHIC
			TIER 1—HMO	TIER 2—IN-NETWORK	TIER 3—OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible	None	None	None	None	\$400/person; \$800/family plus \$500 deductible for each hospital and ambulatory surgical center admission	\$150/person up to a maximum of \$450/family	\$400/person up to a maximum of \$800/family	\$2,000/person \$4,000/family
Annual Out-of-Pocket Maximum	\$1,500/person \$3,000/family	\$1,000/employee \$2,000/employee+1 dependent \$3,000/family	\$1,500/person \$3,000/family	\$3,000/person, \$9,000/family combined for Tiers 2 and 3		\$1,000/person \$2,000/family	\$3,600/person \$7,200/family	\$10,000/person \$15,000/family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	\$5,000,000		\$5,000,000		\$5,000,000
Ambulance	No charge if deemed medically necessary	No charge	No charge	80%	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Chiropractic Care	Not covered	\$15 copay/visit (60 consecutive days/illness or injury combined with physical therapy)	\$15 copay/visit	80%	70% after deductible	90% after deductible; maximum 15 visits/calendar year	70% after deductible; maximum 15 visits/calendar year	Covered as part of physical therapy, see below
			60 consecutive days/illness or injury combined with physical therapy (combined Tiers 1, 2, and 3)					
Emergency Care	\$50 copay (waived if admitted)	\$50 copay/visit (waived if admitted)	\$50 copay (waived if admitted immediately)	\$50 copay (waived if admitted immediately)	\$50 copay (waived if admitted immediately)	\$50 copay (waived if admitted) then 90% after deductible	\$50 copay (waived if admitted) then 90% after deductible; 70% after 48 hours unless the patient cannot be moved	\$100 copay/visit (waived if admitted) then 75%
Home Health Care	No charge if within Kaiser service area	\$15 copay/visit	No charge	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible (up to 100 visits/calendar year)
Hospice Care	No charge at an authorized facility	No charge	No charge	80%	80% after deductible	80% after deductible	80% after deductible	75% after deductible
Hospital Care	No charge	No charge	No charge	80%	70% after deductible; plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	90% after deductible	70% after deductible; plus \$500 deductible/admission (waived for emergency admission), \$500 penalty/admission if not pre-certified	75% after deductible; plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified (non-participating provider only); waived if emergency room admission
Immunizations	No charge	No charge	No charge	No charge	No charge	No charge	Up to \$12 (non-participating provider only)	Up to \$12 (non-participating provider only)
Maternity	No charge	\$15 copay/office visit Delivery no charge	\$15 copay/office visit Delivery no charge	\$25 copay/office visit, delivery 80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible
Mental Health Inpatient	No charge	No charge	No charge	80%	70% after deductible, plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	90% (no deductible)	70% after deductible, plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	75% after deductible, plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission
Mental Health Outpatient	\$15 copay/visit	\$15 copay/visit	\$15 copay/visit	\$25 copay/visit	70% after deductible	\$15 copay/visit	70% after deductible	75% after deductible
Periodic Health Evaluations	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Physical Therapy	\$15 copay/visit	\$15 copay/visit (up to 60 consecutive days/illness or injury; combined with chiropractic care)	\$15 copay/visit	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible; maximum benefit of \$25/visit; maximum of 24 visits/calendar year (non-participating provider only)
Physician Office Visit	\$15 copay/visit; no charge/pediatric visit to age 5	\$15 copay/visit; no charge/pediatric visit to age 5	\$15 copay/visit; no charge/pediatric visit to age 5	\$25 copay/visit; no charge/pediatric visit to age 5	70% after deductible			
Prescription Drug	\$10 copay generic; \$20 copay brand name (for up to a 100-day supply of each medication prescribed by Kaiser physician or any dentist and filled at a Kaiser pharmacy)	\$10 copay generic \$20 copay brand name	\$10 copay generic \$20 copay brand name	\$10 copay generic \$20 copay brand name	\$10 copay generic \$20 copay brand name	\$10 copay generic \$20 copay brand name	\$10 copay generic \$20 copay brand name	75% (after separate \$200 annual deductible)
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	No charge (up to 100 days/calendar year)	No charge	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible (up to 100 days/calendar year)
Surgery	Inpatient: no charge Outpatient: \$15 copay	No charge	No charge	80%	70% after deductible; plus \$500 ambulatory surgical center admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	90% after deductible	70% after deductible	75% after deductible; plus \$500 ambulatory surgical center admission deductible and \$500 penalty/admission if not pre-certified (non-participating provider only); waived if emergency room admission
Vision Care	No charge for eye exam at a Kaiser facility; \$250 allowance/24 months for eyeglass lenses, frames, and contacts at a Kaiser facility	VSP vision benefits: \$15 copay for eye exam every 12 months; \$15 copay for lenses (1 pair every 12 months); \$15 copay for frames every 12 months (\$100 maximum benefit); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	VSP vision benefits: \$15 copay for eye exam every 12 months; \$15 copay for lenses (1 pair every 12 months); \$15 copay for frames every 12 months (\$100 maximum benefit); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	VSP vision benefits: \$15 copay for eye exam every 12 months; \$15 copay for lenses (1 pair every 12 months); \$15 copay for frames every 12 months (\$100 maximum benefit); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	Coverage limited to reimbursement provided under VSP out-of-network schedule	VSP vision benefits: \$15 copay for eye exam every 12 months; \$15 copay for lenses (1 pair every 12 months); \$15 copay for frames every 12 months (\$100 maximum benefit); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	Coverage limited to reimbursement provided under VSP out-of-network schedule	Not covered
X-Ray & Lab	No charge for services at a Kaiser facility	No charge	No charge	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible

 Indicates Plan Changes

This is not an official summary plan description (SPD) or official plan document. If you need a copy of an official plan document, contact the plan's Customer Service department directly. If there is a difference between what you read in this comparison chart and what you read in an official plan document, the official plan document will rule.